TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Michael W. Mann, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-0963-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "POST DESIGNATED DOCTOR EXAMINATION WORK COMP 'SPECIFIC SERVICE' INCORRECT REDUCTION/PARTIAL PAY"

Amount in Dispute: $550.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual communicated its denial to the requestor through its EOB with modifier 892.

No payment is due for the Extent of injury exam."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2016	Referral Doctor Examination (99456-WP, 99456-MI, 99456-RE)	$550.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services with dates of service from March 1, 2008 until September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

1. What are the services considered in this dispute?
2. Are the insurance carrier's reasons for denial of payment supported?

Findings

1. In his Medical Fee Dispute Resolution Request (DWC060), Michael W. Mann, M.D. included procedure codes 99456-WP, 99456-MI, and 99456-RE. Dr. Mann is seeking $0.00 for procedure code 99456-WP. Therefore, this service will not be considered in this dispute. Dr. Mann is seeking $50.00 for procedure code 99456-MI and $500.00 for procedure code 99456-RE. These are the services considered in this dispute.
2. Texas Mutual Insurance Company (Texas Mutual) denied the services in question with claims adjustment reason code 892 – "DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS." 28 Texas Administrative Code §134.204(j)(4)(B) states:

   > When multiple IRs are **required as a component of a designated doctor examination** [emphasis added] under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.

   Submitted documentation does not support that Dr. Mann performed multiple impairment ratings as required as part of a designated doctor examination. The Report of Medical Examination submitted to the division states that Dr. Mann was performing the services as a "Doctor selected by Treating Doctor acting in place of the Treating Doctor." Therefore, billing for multiple impairment ratings using procedure code 99456-MI is not supported. No reimbursement is recommended for this service.

   28 Texas Administrative Code §134.204(k) states, in relevant part:

   > The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. **When conducting a Division or insurance carrier requested RTW/EMC examination** [emphasis added], the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE" …

   Because the examination in question was not requested by the division or insurance carrier, billing for an evaluation to determine the extent of the compensable injury using procedure code 99456-RE is not supported. No reimbursement is recommended for this service.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	December 30, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.